

<b>Case Number:</b>	CM14-0048670		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	07/20/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	03/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 44 year old male whose date of injury is 07/20/2012. The mechanism of injury is described as repetitive work activities including welding. Maximum medical improvement report dated 10/31/13 indicates that diagnoses are cervical spine disc herniation without myelopathy, and left shoulder rotator cuff syndrome. The injured worker was determined to have reached maximum medical improvement with 13% whole person impairment. MRI of the cervical spine dated 01/09/14 revealed disc desiccation at C5-6. At C3-4 there is a focal central posterior disc protrusion deforming the ventral thecal sac. Evaluation dated 02/06/14 indicates that diagnoses are bilateral shoulder sprain/strain with internal derangement on the left, tendinitis/impingement syndrome of the bilateral shoulders, bilateral wrist sprain and strain, and early bilateral carpal tunnel syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Multi- Stim unit- rent for 7 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation; Neuromuscular electrical stimulation and Transcutaneous electrical nerve stimulation Page(s): 116,120 and 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** Based on the clinical information provided, the request for multi-stim unit rent for 7 days is not recommended as medically necessary. There is no indication that the injured worker has undergone any recent active treatment. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. Therefore, the requested rental of a stimulator is not in accordance with Chronic Pain Medical Treatment Guidelines and medical necessity is not established.